

## **Dental Benefits – Claim Instructions**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

#### TO THE EMPLOYEE

- 1. Complete items one (1) through twenty-seven (27) in full. Be certain to sign the authorization to release information block (28).
- 2. If you wish to have your benefits for this claim paid directly to your dentist, sign the block (29).

If total charges for the planned course of treatment are expected to exceed the minimum Predetermination dollar amount stated in your dental plan booklet, it is suggested you file for Predetermination of Benefits. Aetna U.S. Healthcare will notify your dentist of the benefits payable.

NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR DENTAL BOOKLET FOR DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND COPAYMENT INFORMATION, AND LIMITATIONS AND EXCLUSIONS.

#### TO THE DENTIST

- 1. COMPLETED SERVICES Check the box noted "STATEMENT OF SERVICES RENDERED" and complete items 30 through 46. When entering the treatment plan on the form, please indicate a separate fee for each individual service rendered.
- 2. PREDETERMINATION OF BENEFITS If total charges for this claim are to exceed the minimum Predetermination dollar amount indicated in the employee's Dental Plan Booklet (and treatment is not emergency in nature), Predetermination of Benefits is suggested. Check the box marked "PRE-TREATMENT ESTIMATE", and complete items 30 through 46.

NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE EMPLOYEE, DENTIST AND INSURANCE COMPANY CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.

3. If the employee indicates that benefits should be paid directly to the dentist, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

\*X-rays taken for metal restorations and crowns should be submitted with treatment plan. They may also be requested for other services. X-rays will be reviewed by practicing Dentists and returned promptly.

### TO THE EMPLOYEE & DENTIST

Send the completed benefits request and the bills to: Aetna U.S. Healthcare

P.O. Box 14586

Lexington, KY 40512-4586

1-800-367-6276



# **Dental Benefits Request**

Mail to: Aetna U.S. Healthcare P.O. Box 14586

Lexington, KY 40512-4586

TO BE COMPLETED BY EMPLOYEE																	
1.	Employer's Name <b>Department of</b>	2. Policy/Group Number Branch Number 721027															
3.	Employee's Social Security Number	4. E	mployee's									5. Employee's Birthdate (MM/DD/YYYY)					
6.	Active Retired  Date of Retirement	e zip code)						8. Employee's Daytime Telephone Number									
9. Patient's Name 10. Patient's Social Secu					rity Number 11. Patient's B				te (MM/DD/YYYY)				elationship to Employee  Spouse Child Other				
13. Patient's Address (if different from employee)  14. Patient's Sex  Male Female					15. Full Time Student 16. Patient's Expected Graduation Date 17. Name of School Cit												
18	Patient's Marital Status  ☐ Married ☐ Single  19. Is patient employed? ☐ No ☐ Yes					20. Name & Address of Employer											
21	. Are any family members expenses covered to Cross-Blue Shield, etc.), no fault auto insurar No Yes	ore-payment plan (Blue r local government plan?  22. If yes, list policy or contract holder, policy or contract or administrator:						contract	number(s) and name/address of insurance company								
23	3. Member's Social Security Number 24. Member's Name						·						25. Member's Birthdate (MM/DD/YYYY)				
26	claim related to an accident?  No Yes If yes, date					time							27. Is claim related to employment?  No Yes				
	To all providers of dental care: You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting dental professionals and utilization review organizations with whom Aetna has contracted, information concerning dental care, advice, treatment or supplies provided the patient. This information will be used to evaluate claims for dental benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted.  I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.  Patient's or Authorized Person's Signature																
29	9. I authorize payment of dental benefits to the dentist or supplier of service.  Patient's or Authorized Person's Signature												Date				
Т	O BE COMPLETED BY DENTIS																
	). This is a	<u>,,                                   </u>															
21	Request for Pre-Treatment Estimate Statement of Services Rendered  31. Dentist's Name & Address (include zip code) 32. Telephone No.												22	Dentist License No.			
,						34. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.  35. First Visit Date Current Series 36. Place of Treatment 37. Radiographs or models enclosed?											
In treatment result of:						Office Hosp. ECF Otl											
Is treatment result of:  No Yes  38 occupational illness or injury?					If yes, enter brief description and dates												
38. occupational illness or injury?  39. auto accident?																	
40	other accident?																
	. Are any services covered by another plan?																
	2. If prosthesis, is this initial placement? 3. Is treatment for orthodontics?	If no, date of prior placement and reason for replacement															
TO IS BECAUTER TO STATEMENT OF THE STATE						Date appliance placed:  No. of months of treatment:  Mos. of treatment remaining:  Initial Appliance I Monthly Fee: Total Case Fee:							-ee:				
44		5. Exam	nination an	d treatm	ent plan	. List in order	from tooth no. 1	through	tooth no. 32.	Use charting system	shown.						
	~\@(D)(D)\@\~	ooth # If Previously				Surface Description of Service (x-rays, prophylaxis, r				ylaxis, materials			Performed	Procedure	Fee		
or Letter Extracted, Give Dai			ve Date		used, etc.)				MM	DD I	YYYY	Number					
Da Che For Board											<u> </u>						
											<u>.                                      </u>	<u> </u>					
	මු <sub>ම්</sub> ලා																
Dai Cas Fingial r (2) 16 (2) Cas										·							
	######################################																
	FACIAL																
46	i. I hereby certify that the procedures as		-				and that the fe	es subi	mitted are th	ne actual fees I		charg		S			
	have charged this patient and intend t				cedures		_					unt pa					
	Dentist's Signature						Date				Balai	nce du	ie §				